



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

CONTROE REGIONAL MEDICAL CENTER  
C/O T DANIEL HOLLOWAY  
3701 KIRBY DRIVE SUITE 1288  
HOUSTON TX 77098

DWC Claim #:  
Injured Employee:  
Date of Injury:  
Employer Name:  
Insurance Carrier #:

#### **Respondent Name**

TEXAS MUTUAL INSURANCE CO

#### **Carrier's Austin Representative Box**

Box Number 54

#### **MFDR Tracking Number**

M4-07-8063-01

#### **MFDR Date Received**

AUGUST 13, 2007

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "As required by law, Conroe Regional Medical Center billed its usual and customary charges for its services. The total sum billed was \$55,988.79... Per Rule 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of \$40K, the entire admission will be paid using the stop-loss reimbursement factor ('SLRF') of 75%... ...the fee paid by Texas Mutual Insurance Company do not conform to the reimbursement section of Rule 134.401... The carrier's position is incorrect and in violation of the ACIHFG... ...it is the position of Conroe Regional Medical Center that all charges relating to the admission of [injured employee] are due and payable as provided for under Texas law and Rules of the Division."

**Amount in Dispute:** \$35,353.57

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The following is the carrier's statement with respect to this dispute. The diagnosis code listed on the requestor's bill is 823.22, a closed fracture of the tibia fibula bones. More importantly, it means the MAR for this dispute is to be fair and reasonable. The requestor billed \$55,988.79 but proposes a fee of \$41,991.58... Medicare would pay \$10,145.84 for the services in dispute... The requestor's proposed fee is some 413.87% that of Medicare... The requestor believes it should receive 75% of its billed charges because its billing is subject to stop loss provision of DWC's hospital fee guideline. However, as Texas Mutual has already pointed out the MAR is fair and reasonable... Texas Mutual does not believe the requestor has proven that its proposed fee is fair and reasonable nor is due any additional payment beyond the amount that was paid."

**Response Submitted by:**

### **SUMMARY OF FINDINGS**

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
February 12, 2007 through February 15, 2007	Inpatient Services	\$35,353.57	\$0.00

## ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401 sets out the fee guideline for acute care inpatient hospital services.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - W1 – Workers Compensation State Fee Schedule adjustment.
  - W10 – No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
  - 97 – Payment is included in the allowance for another service/procedure.
  - 217 – The value of this procedure is included in the value of another procedure performed on this date.
  - 426 – Reduced to fair and reasonable.
  - 480 – Reimbursement based on the Acute Care Inpatient Hospital Fee Guideline per diem rate allowances.
  - 719 – Reimbursed as carrier's fair & reasonable cost data unavailable for facility. Additional payment may be considered if data is submitted.
  - 420 – Supplemental payment.
  - 143 – Portion of payment deferred.
  - 891 – The insurance company is reducing or denying payment after reconsideration.
  - 18 – Duplicate claim/service.
  - 878 – Duplicate appeal. Request medical dispute resolution through DWC for continued disagreement of original appeal decision.

### **Findings**

1. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 823.22.
2. The requestor asks for reimbursement under the stop loss provision of the Division's *Acute Care Inpatient Hospital Fee Guideline* found in Division rule at 28 TAC §134.401(c)(6). The requestor asserts in the position statement that "Per Rule § 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of \$40K, the entire admission will be paid using the stop-loss reimbursement factor ('SLRF') of 75%." "Therefore, the fees paid by the Carrier in this case do not conform to the reimbursement section of Rule § 134.401..." Division rule at 28 TAC §134.401(c)(6), effective August 1, 1997, 22 TexReg 6264, states, in part, that "The diagnosis codes specified in paragraph (5) of this subsection are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate." As stated above, the Division has found that the primary diagnosis is a code specified in Division rule at 28 TAC §134.401(c)(5); therefore, the disputed services are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 TAC §134.1.
3. Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

5. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to requests filed on or after May 25, 2008, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable.” Review of the submitted documentation finds that:
- The requestor’s position statement / rationale for increased reimbursement from the *Table of Disputed Services* asserts that “Per Rule § 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of \$40K, the entire admission will be paid using the stop-loss reimbursement factor (‘SLRF’) of 75%.”
  - The requestor does not discuss or explain how additional payment of \$35,353.57 would result in a fair and reasonable reimbursement.
  - The requestor seeks reimbursement for this admission based upon the stop-loss reimbursement methodology which is not applicable per Division rule at 28 TAC §134.401(c)(6).
  - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
  - The Division has previously found that a reimbursement methodology based upon payment of a hospital’s billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:  
“A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources.”
  - The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.
  - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
  - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

## **Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

## **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

## **Authorized Signature**

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Signature

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Medical Fee Dispute Resolution Officer

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December 12, 2012  
Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**